WASATCH COUNTY HOSPITAL

Admission Sheet

Hospital No. 6585

Full Name Luther Marion Rhodes

Address 761 No 1050 East

Provo, Utah

Date 9-27-74 Room No. ____

Hour 11:00 (AM) PM Religion ____

Date of Birth 4/03/91 Age 80

M S W (D) Sex M

Occupation ____

Doctor Rhodes

Admitted to: (Med) Surg OB

Prev. Hospitalization here: Yes (No)

Nearest Rel. J. Robert R. Rhodes

Address ____

Relation to Patient Grandson

Telephone ____

Responsible Party self.

Hospital Ins. Medicare

Policy No. Welfare ____

Contract ____

Group ____

Medicare 538-30-6696-A

Employer ____

Employer's Address ____

The following only for Obstetrical Cases

Father's Full Name ____ Occupation ____ Age ____

Present Address ____ Birthplace ____

Mother's Birthplace ____

Remarks ____

CONSENT TO MEDICAL and/or SURGICAL TREATMENT

Heber City, Utah 9-27-74 11:00 (AM) PM

I hereby authorize the Physician in charge of the care of Luther M. Rhodes to administer any treatment, or to administer such anesthetics and perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Sig. of Patient ____ Nearest Rel. [signature]

Witness Marjorie McKinnon Relationship to Pt. ____

This consent must be signed by the patient, or if the patient is a minor or not competent to give legal consent, by the nearest relative, or failing a relative, by the nearest friend.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Wasatch County Hospital to release the information requested by the Insurance Companies.

Date ____ Signed ____

Patient (Parent if Minor)

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payment directly to the Wasatch County Hospital of the Policy Benefits therein specified and otherwise payable to me, but not to exceed the hospital's regular charges for this period of hospitalization. I understand that I am financially responsible to the hospital for charges not covered by this authorization.

Date ____ Signed ____

Policyholder

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